Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SAINT ALPHONSUS REGIONAL MEDICAL
CENTER
PO BOX 190930
BOISE ID 83719

Respondent Name

TPCIGA for RELIANCE NATIONAL INSURANCE

Carrier's Austin Representative Box

Box Number 50

MFDR Tracking Number

M4-12-0044-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as stated on the Table of Disputed Services: "Out of state providers should be paid based on the fee schedule in which the services are rendered. Additional payment is being requested to equal the Idaho Fee Schedule for reimbursement on services rendered. Please see attached copy of Idaho fee schedule for payment guidelines."

Amount in Dispute: $117.12

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Requestor is an out-of-state provider who claims that they should not be paid pursuant to the Texas workers' compensation fee guidelines. However, that is incorrect. Requestor chose to accept the Claimant knowing his treatment was covered under Texas workers' compensation. Requestor, by accepting this patient, is bound by the Texas Labor Code and the corresponding rules. Texas Labor Code §408.027(f) states that any payment made by an insurance carrier shall be made in accordance with the fee guidelines if the health care service is not provided through a workers' compensation health care network or at a contracted rate. The treatment at issue was not provided through a workers' compensation health care network, and no contract exists for the services. Thus, Respondent is bound by this statute to pay pursuant to the fee guidelines established by the Texas Labor Code. Further, DWC Rule 134.1(e)(1) states that medical reimbursement not provider through a workers' compensation healthcare network shall be made in accordance with the Division's fee guidelines. Respondent paid the medical bill in dispute in accordance with the Division's fee guidelines. There is no exception to this rule for out-of-state providers. In conclusion, Respondent requests that a Findings and Decision be issued which states that no additional reimbursement is owed as Requestor was correctly paid in accordance with the Texas Labor Code and the Division's fee guidelines."

Response Submitted by: Downs-Stanford, PC, 2001 Bryan Street, Suite 4000, Dallas, TX 75201

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 2, 2011	CPT Code 72100 ($14.87 x 125% = $18.59 - $26.94 (carrier payment))	$73.04	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.403(b)(1), (c)(1) and (c)(3) sets out the payment policies and procedures for the Division of Workers' Compensation and it's system participants to calculate the MAR for outpatient surgical services.
3. 28 Texas Administrative Code §134.203 sets out the payment policies and procedures for the Division of Workers' Compensation and it's system participants to calculate the MAR for outpatient services paid under a fee schedule
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated May 20, 2011 and May 9, 2008
   - 170 – Reimbursement is based on the outpatient/inpatient fee schedule.
   - 802 – Charge for this procedure exceeds the OPPs Schedule allowance.
   - W1 – Workers Compensation State Fee Schedule adjustment.
   - QA – The amount adjusted is due to bundling or unbundling of services.

Issues

1. Under what authority is a request for medical fee dispute resolution considered?
2. Did the requestor submit the request for medical fee dispute resolution in accordance with 28 Texas Administrative Code §133.307?
3. Was the requestor reimbursed in accordance with 28 Texas Administrative Code §134.403 and is the requestor entitled to reimbursement?

Findings

1. The requestor provided surgical services in the state of Idaho January 28, 2008 through January 31, 2008 to an injured employee with an existing Texas Workers' Compensation claim. The requestor was dissatisfied with the respondent's final action. The requestor filed for reconsideration and was denied payment after reconsideration. The requestor filed for dispute resolution under 28 Texas Administrative Code §133.307. The Division concludes that because the requestor sought the administrative remedy outlined in 28 Texas Administrative Code §133.307 for resolution of the matter of the request for additional payment, the dispute is to be decided under the jurisdiction of the Texas Workers' Compensation Act and applicable rules.
2. The requestor submitted the request for medical fee dispute resolution in accordance with 28 Texas Administrative Code 133.307.
3. Procedure code 72100 has a status indicator of X, which indicates ancillary services paid under OPPS with separate APC payment. The payment rate for APC 0260 is listed in OPPS Addendum A as $45.04. This amount multiplied by 60% yields an unadjusted labor-related amount of $27.02. This amount multiplied by the annual wage index for this facility of 0.9258 yields an adjusted labor-related amount of $25.02. The non-labor related portion is 40% of the APC rate or $18.02. The sum of the labor and non-labor related amounts is $43.03. The APC payment for this service is $43.03. The outlier payment amount is $0. The total APC payment for this service, including outliers, is $43.03. This amount multiplied by 200% yields a MAR of $86.07.
4. Review of the submitted documentation finds that the Requestor was paid in accordance with 28 Texas Administrative code §134.401(c)(1), §134.401(c)(2), §134.401(c)(4)(B)(i); and §134.203 therefore, additional reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 10, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.